STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152027	A. BUILDING 00 B. WING	02/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VIBRA HOSPITAL OF FORT WAYNE	2626 FAIRFIELD AVE FORT WAYNE, IN 46807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	This visit was for a State hospital licensure survey. Dates: 2/21/2012 through 2/22/2012 Facility Number: 012132 Surveyors: Albert Daeger, CFM, SFPIO Medical Surveyor Saundra Nolfi, RN PH Nurse Surveyor QA: claughlin 03/02/12	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0308	410 IAC 15-1.4-1 GOVERNING BOARD 15-1.4-2 (c)(6)(B) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies. Based on review of personnel files, facility in-service documentation, policy and procedure review, and interview, the governing board failed to ensure all employees received departmental orientation in 4 of 24 files reviewed (#P5, P10, P11, and P21), received annual fire safety and infection control education in 3 of 24 files (#P7, P10, and P11), and received annual blood competency training in 7 of 8 nurses (#P2, P11, P12, P13, P14, P15, and P17). Findings included: 1. Review of personnel files with staff member #A8 at 10:00 AM on 02/22/12 indicated the following: A. No departmental orientation for staff	S0308	· Annual education restructured to include glucose testing and blood administration. · Compliance will be reported through the Quality Council monthly# of employees with documentation of annual education/ total # of employees· Mandatory education given to all clinical staff on findings from the survey· All education documents are being placed in the employees files· Staff members that do not comply with annual mandatory training by 3/27/12 will be removed from the schedule· The department orientation has been revised to allow completion for the new employees by the end of their introductory period (90 days) · Compliance will be reported through the Quality Council **Responsible Party:** HR Director	03/27/2012

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	members #P5 (hired 8/24/10), P10 (hired 9/03/09), P11 (hired 10/01/07), and P21 (hired 03/11). B. No Fire Safety or Infection Control for staff member #P7 (hired 08/10/10) since 12/10. C. No Fire Safety or Infection Control for staff member #P10 (hired 09/03/09) since 12/10. D. No Fire Safety or Infection Control for staff member #P11 (hired 10/01/07) since 01/11. 2. Review of the facility's education sign-in record for the Blood Products Administration training conducted on 10/26/11 failed to indicate attendance by 7 of 8 nurses employed for over a year (#P2, P11, P12, P13, P14, P15, and P17). The employee files also failed to indicate documentation of the annual training. 3. The facility policy titled "Departmental Training", last reviewed 04/2011, indicated "...1. All employees must attend the general safety and fire training for new employees and annual retraining sessions, as provided by the Human Resources Department. ...11. Copies of all training documents will be kept in the employees file." The facility mandatory educational requirements for 2011 included Infection Control and Blood Borne Pathogens training.			

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	4. At 11:30 AM on 02/22/12, staff member #A8 confirmed the findings and indicated the Fire Safety/Infection Control training conducted in January 2011 was late and was actually the 2010 annual training. 5. At 1:00 PM on 02/22/12, staff member #A2 indicated he/she conducted the blood administration training twice a year and all nurses were expected to attend. He/she could not provide any other documentation of training for the nurses who were not at the October 2011 training.			

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S0596	410 IAC 15-1.5-2 INFECTION CONTROL 410 IAC 15-1.5-2(f)(3)(D)(iii) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (iii) Cleaning, disinfection, and sterilization. Based on observation, interview, policy and procedure review, and manufacturer's directions, the infection control committee failed to ensure the patient rooms were adequately disinfected by the housekeeping staff. Findings included: 1. During the tour of the patient care unit at 9:30 AM on 02/22/12, accompanied by staff members #A2 and A6, the housekeeping cart was observed with a bucket of sanitizing solution with rags and a supply of clean, dry rags. The housekeeping closet contained an automated dispensing system for the different chemicals used on the unit.	S0596	· Mandatory staff education is being provided to all staff members involved in the cleaning and disinfecting processes of the hospital# of staff with documented education/ # of staff requiring education on cleaning processes· The education and training includes the acknowledgment of disinfectant “kill times” and allowing the surfaces to air dry· The room cleaning policies have been changed to reflect the name and type of solution that is being utilized for cleaning· The policies will be submitted for approval via the hospital’s committee structure Audit will be conducted of compliance and report to EOC committee**Responsible Party:** Director of Plant Ops	03/27/2012

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	2. At 10:05 AM on 02/22/12, the environmental services supervisor, staff member #A6, indicated the disinfectant used to clean the patient rooms was 20 Neutral Disinfectant Cleaner. He/she indicated the surfaces were wiped with a rag from the premixed solution then dried with a clean, dry rag. When questioned, he/she indicated there was no waiting or "kill time". Staff member #A6 indicated he/she trained the housekeeping staff members in the proper cleaning procedures. 3. The facility policy titled "Cleaning Patient Room Occupied", last revised 02/2011, indicated, "...All over-bed tables, bed-side tables, wardrobes, telephones, chairs, stools, ledges, light switches, lamps, and spots on walls or cabinets will be damp dusted and cleaned with a hospital approved germicidal solution. Germicidal solution will be changed every three patient rooms or more as needed." The policy did not specify exactly what solution to use or how to use it. 4. The manufacturer's literature with the 20 Neutral Disinfectant Cleaner indicated under "Disinfection/Cleaning/Deodorizing, ...Let solution remain on surface for a			

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	minimum of 10 minutes. Rinse or allow to air dry."			

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S0672	410 IAC 15-1.5-3 LABORATORY SERVICES 410 IAC 15-1.5-3(e) (e) All nursing and other hospital personnel performing out-of-laboratory testing shall have annually updated performance certification maintained in the employee file for the procedures being performed. Based on personnel file review, facility educational records, and interview, the facility failed to ensure all nurses had annual glucometer competency in 8 of 8 nursing files reviewed (#P2, P11, P12, P13, P14, P15, P16, and P17). Findings included: 1. Review of personnel files at 10:00 AM on 02/22/12 with staff member #A8 failed to evidence documentation of annual glucometer competency for 8 of 8 nurses who had been employed for over a year (#P2, P11, P12, P13, P14, P15, P16, and P17). 2. Review of the facility's Accucheck Inservice Training sign-in sheet from 01/20/11 indicated signatures for staff nurses #P2, P11, P12, P15, P16, and P17, but lacked signatures for staff nurses #P13 and P14. 3. At 11:30 AM on 02/22/12, staff member #A8 indicated the January 2011	S0672	· Staff in-service for licensed clinical staff with mandatory testing to cover the proper way to fill out the blood transfusion administration record· Annual education to include Point of Care testing training for all appropriate personnel. # of licensed clinical staff in-serviced/ # of licensed clinical staff· Annual compliance training reported through Quality Council monthly· All training and tests will be placed in the employee files**Responsible Party:** HR Director	03/27/2012

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	training was actually the competency for 2010 and he/she did not have any records for the 2011 training. 4. At 1:00 PM on 02/22/12, staff member #A2 confirmed the findings and indicated nurses do perform blood sugar testing with the glucometer.			

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S0744	410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4 (e)(1) (e) All entries in the medical record shall be: (1) legible and complete; Based on medical record review, medical staff rules and regulations review, policy and procedure review, and interview, the facility failed to ensure entries were legible and complete and corrected according to policy in 15 of 20 closed records reviewed (#N1, N2, N3, N6, N7, N8, N9, N10, N12, N13, N14, N15, N17, N19, and N20). Findings included: 1. The medical record for patient #N1, admitted 09/20/11, had entries marked out and scribbled out on the Physician Orders sheets. 2. The medical record for patient #N2, admitted 09/20/11, had entries scribbled out on the Physician Orders sheets. 3. The medical record for patient #N3, admitted 08/12/11, had entries marked out and scribbled out on the Physician Orders sheets. 4. The medical record for patient #N6,	S0744	· Mandatory clinical staff education was provided for proper correction of an error in the medical record# of clinical staff with documented education/ total # of clinical staff· Educational packet regarding appropriate error correction was prepared and distributed to physicians· Policy "Charting Errors and Omissions" revised for clarity· Policy will be submitted for approval via the hospital's committee structure **Responsible Party:** HIMADDENDUM: The auditing of charting errors and omissions will be completed along with the current monthly auditing conducted by HIM.	03/27/2012

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	admitted 10/28/11, had entries marked out and scribbled out on the Physician Orders sheets, Total Parenteral Nutrition Orders, Intake/Output Record, 24 Hour Flow Sheet, and the Glucose Flowsheet. The Glucose Flow Sheet also lacked dates for some of the entries. 5. The medical record for patient #N7, admitted 09/22/11, had entries marked out and scribbled out on the Physician Orders sheets. The Death Checklist lacked a signature of the hospital representative releasing the body. 6. The medical record for patient #N8, admitted 12/12/11, had entries written over/changed on the 24 Hour Flow Sheet. The Death Checklist lacked a signature of the hospital representative releasing the body. 7. The medical record for patient #N9, admitted 07/28/11, had entries written over/changed on the Physician Orders Sheet and the Glucose Flowsheet. The Glucose Flow Sheet also lacked dates for some of the entries. 8. The medical record for patient #N10, admitted 10/13/11, had entries written over/changed on the Glucose Flowsheets. The Glucose Flow Sheets also lacked dates and signatures for some of the			

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	entries. 9. The medical record for patient #N12, admitted 10/05/11, had entries marked out/changed on the Physician Orders sheets. 10. The medical record for patient #N13, admitted 10/02/11, had entries marked out/changed on the Physician Orders sheets. 11. The medical record for patient #N14, admitted 08/24/11, had entries written over/changed and scribbled out on the Physician Orders sheets and the Glucose Flowsheets. The Glucose Flow Sheets also lacked dates and signatures for some of the entries. 12. The medical record for patient #N15, admitted 09/03/11, had entries written over/changed on the Glucose Flowsheet. The Glucose Flow Sheet also lacked dates and signatures for some of the entries. 13. The medical record for patient #N17, admitted 08/03/11, had entries written over/changed on the Glucose Flowsheet. The Glucose Flow Sheet also lacked dates and signatures for some of the entries. 14. The medical record for patient #N19, admitted 07/22/11, had entries written			

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	over/changed on the Physician Orders sheets and the Glucose Flowsheets. The Glucose Flow Sheets also lacked dates and signatures for some of the entries. 15. The medical record for patient #N20, admitted 09/02/11, had entries written over/changed and scribbled out on the Physician Orders sheets and the Glucose Flowsheets. The Glucose Flow Sheets also lacked dates and signatures for some of the entries. 16. The facility's 2010 Medical Staff Rules and Regulations indicated, "...7. All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated. All entries must be legible." 17. The facility's policy titled "Medical Record Documentation Requirements", last reviewed February 2012, indicated, "...19. Corrective action for inappropriate error correction- please discuss with clinical staff. Line through the incorrect data with a single line, in ink, leaving the original writing legible. The person should note the reason for the change (error), date the correct data and sign the documentation. The correction or amendment of the medical record should never involve erasure or obliteration of the original documentation."			

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	18. At 1:00 PM on 02/22/12, the medical record findings were reviewed and confirmed by staff members #A1 and A2.			

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S0871	410 IAC 15-1.5-5 Medical Staff 410 IAC 15-1.5-5(b)(3)(O) (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following: (O) A requirement that all verbal orders must be authenticated by the responsible individual in accordance with hospital and medical staff policies. The individual receiving a verbal order shall date, time, and sign the verbal order in accordance with hospital policy. Authentication of a verbal order must occur within forty-eight (48) hours unless a read back and verify process described under items (i) and (ii) is utilized. If a patient is discharged within forty-eight (48) hours of the time that the verbal order was given, authentication shall occur within thirty (30) days after the patient's discharge. (i) As an alternative, hospital policy may provide for a read back and verify process for verbal orders. Any read back and verify process must require that the individual receiving the order shall immediately read back the order to the ordering physician or other responsible individual who shall immediately verify that the read back order is correct. (ii) The individual receiving the verbal order shall document in the patient's medical record that the order was read back and verified. Where the read back and verify process is followed, the hospital shall require authentication of the verbal order not later than thirty (30) days after the patient's discharge.			

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	Based on medical record review, policy and procedure review, and interview, the facility failed to ensure the staff documented "read back and verified (r/v)" for physician orders that were obtained verbally or by telephone for 10 of 20 closed in-patient records reviewed (#N1, N2, N3, N5, N9, N13, N16, N18, N19, and N20). Findings included: 1. The medical record for patient #N1 indicated physician orders received verbally by the nurse on 10/20/11 and via the telephone on 10/24/11, but lacked documentation of "read back and verified" or R/V. 2. The medical record for patient #N2 indicated physician orders received via the telephone by the nurse on 10/06/11, but lacked documentation of "read back and verified" or R/V. 3. The medical record for patient #N3 indicated physician orders received via the telephone by the nurse on 08/17/11, but lacked documentation of "read back and verified" or R/V. 4. The medical record for patient #N5 indicated physician orders received via the telephone by the nurse on 10/02/11,	S0871	· Mandatory education provided to clinical staff on how to properly obtain and document a verbal or telephone order utilizing the “read back and verified (r/v)” method# of clinical staff with documented education/ total # of clinical staff· Physician staff members were sent educational information in regards to the authentication requirements of the verbal and telephone orders requiring not only the signature, but also date and time· The lack of physician compliance will be shared during the next MEC· The monitoring of the compliance will be shared monthly with Quality Council Committee (monitoring beginning 3/1/12) · Authentication of verbal and telephone orders will be added to the physicians OPPE/FPPE· All OPPE/FPPE reports will be submitted via the committee structure through to the GB**Responsible Party:** HIM	03/27/2012

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VIBRA HOSPITAL OF FORT WAYNE	2626 FAIRFIELD AVE FORT WAYNE, IN 46807

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	but lacked documentation of "read back and verified" or R/V. 5. The medical record for patient #N9 indicated physician orders received via the telephone by the nurse on 08/03/11 and 08/15/11, but lacked documentation of "read back and verified" or R/V. 6. The medical record for patient #N13 indicated physician orders received via the telephone by the nurse on 10/02/11, but lacked documentation of "read back and verified" or R/V. 7. The medical record for patient #N16 indicated pharmacist's orders received via the telephone by the nurse on 09/15/11, but lacked documentation of "read back and verified" or R/V. 8. The medical record for patient #N18 indicated physician orders received via the telephone by the nurse on 09/07/11, but lacked documentation of "read back and verified" or R/V. 9. The medical record for patient #N19 indicated physician orders received via the telephone by the nurse on 07/29/11 and 08/06/11, but lacked documentation of "read back and verified" or R/V. 10. The medical record for patient #N20			

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	indicated physician orders received via the telephone by the nurse on 10/01/11, but lacked documentation of "read back and verified" or R/V. 11. All of the above medical records had the orders authenticated by a physician, but lacked documentation of a date or time. 12. The facility policy titled "Physician's Orders", last reviewed 03/11, indicated, "...Verbal orders/Telephone orders must be read back to the ordering physician for validation and clarification of the orders. ...Physician must countersign orders as soon as possible. ...Orders are dated and authenticated if necessary. ...All verbal or telephone orders will have documented 'read back' after they are recorded by the licensed staff receiving them to confirm accuracy of the order." 13. At 1:15 PM on 02/22/12, the medical record findings were reviewed and confirmed by staff members #A1 and A2.			

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S0872	410 IAC 15-1.5-5 MEDICAL STAFF 410 IAC 15-1.5-5(b)(3)(P) (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following: (P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge. Based on medical record review, policy and procedure review, and interview, the medical staff failed to complete the discharge summary within 30 days in 3 of 20 records reviewed (#N8, N11, and N18). Findings included: 1. The medical record for patient #N8, who was discharged 12/26/11, indicated a Discharge Summary dictated 02/02/12. 2. The medical record for patient #N11, who was transferred 11/02/11, indicated a Discharge Summary dictated 12/18/11. 3. The medical record for patient #N18, who was discharged 09/09/11, indicated a Discharge Summary dictated 11/09/11.	S0872	· Physician staff members were sent re-education along with the standard of care per Vibra policy on delinquencies and completion of discharge summaries · The lack of physician compliance will be shared during the next MEC · The monitoring of the compliance will be shared monthly with QAPI (monitoring beginning 3/1/12) · Timeliness of discharge summaries will be added to the physicians OPPE/FPPE · All OPPE/FPPE reports will be submitted via the committee structure through to the GB **Responsible Party:** HIM	03/27/2012

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	4. The facility policy titled "Medical Record Documentation Requirements", last reviewed February 2012, indicated on page 3, "...21. Medical records shall be completed by the physician, dentist, podiatrist, or other individual authorized within the scope of his or her professional license within 30 days of the patient's discharge." 5. At 1:00 PM on 02/22/12, the medical record findings were reviewed and confirmed by staff members #A1 and A2.			

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S0952	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6(d) (d) Blood transfusions and intravenous medications shall be administered in accordance with state law and approved medical staff policies and procedures. If the blood transfusions and intravenous medications are administered by personnel other than physicians, the personnel shall have special training for these procedures in accordance with subsection (b)(6). Based on medical record review, facility blood transfusion training, and interview, the facility failed to follow their established procedure for blood transfusion administration in 8 of 8 patients who received blood (#N1, N2, N3, N4, N5, N9, N15, and N20). Findings included: 1. The Transfusion Administration Record (TAR) from 09/29/11 for patient #N1 had the issue time marked out. 2. The TAR from 09/23/11 for patient #N2 had the issue time from another hospital listed on the form. Documentation indicated the start time was 1725 and the 15 minute vital signs were also at 1725. Documentation for the last 30 minute assessment was missing. A second TAR from 09/23/11 had the	S0952	· Mandatory education was done for all licensed clinical staff on blood administration· The mandatory education was accompanied with a written test· Revision of annual competencies to include Blood Administration for all appropriate clinical staff.· All licensed staff members will have this education present in their file· The monitoring of compliance will be performed on all blood TAR's# of blood TAR's completed accurately/ total # of blood TAR's· The compliance information will be submitted via the Quality Council meeting monthly**Responsible Party:** HR Director	03/27/2012

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	issue time from the other hospital on the form. 3. The TAR from 08/21/11 for patient #N3 had the issue time marked out and documentation of a start time of 1525 with the 15 minute vitals signs written over/changed to 1550. A second TAR from 08/21/11 also had the issue time marked out and the end time written over/illegible. 4. The TAR from 11/25/11 for patient #N4 had the issue time marked out and a start time of 1855, but the 30 minute pre-vital signs were documented as 1900. The 15 minute vital signs were documented as 1930 and the immediate post-transfusion vital signs and the 1 hour transfusion assessment lacked any times. A second TAR from 11/25/11 had the issue time marked out and no time for the 30 minute pre-vital signs. 5. The TAR from 10/01/11 for patient #N5 had the issue time from another hospital listed on the form. Documentation indicated the start time was 1345 and the 15 minute vital signs were also at 1345. A second TAR from 10/01/11 had the issue time from the other hospital on the form, a start time of 1600, and the 15 minute vital signs as 1630.			

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	6. The TAR from 08/02/11 for patient #N9 had the issue time marked out and documentation of a start time of 2215 with the 15 minute vital signs as 2245. A second TAR from 08/03/11 also had the issue time marked out, a start time of 0120, and the 15 minute vital signs written over/changed to 0200. 7. The TAR from 09/06/11 for patient #N15 had the issue time marked out and documentation of a start time of 1900 with no time for the 30 minute pre-vital signs or any time or initials for the 15 minute assessment. The first 30 minute assessment was timed as 2015. A second TAR from 09/06/11 also had the issue time marked out, a start time of 0950, and the 15 minute vital signs as 1015. 8. The TAR from 09/16/11 for patient #N20 had the issue time from the other hospital on the form, but no time for the immediate post-transfusion vital signs or the 1 hour post-transfusion assessment. A second TAR from 09/16/11 also had the issue time from the other hospital, but lacked times for any of the vital signs or assessments. A third TAR from 09/25/11 had the issue time marked out. A fourth TAR from 09/25/11 had the issue time marked out and lacked documentation of the end date and time and time for the			

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	immediate post-transfusion vital signs. 9. Review of the facility's material for blood transfusion training indicated the following: "...Obtain pre-transfusion vital signs within 30 minutes of the beginning of transfusion. ...On the TAR, note the time the unit was removed from the cooler as the Issue Time. ...An RN must remain with the patient for the first 15 minutes of the transfusion. Nurse to check vital signs and assess patient 15 minutes after initiation of transfusion. A licensed professional must then perform assessment of patient every 30 minutes until completion of transfusion. Initial the area indicated on the TAR. Vital signs must be checked at completion of transfusion and an assessment performed one hour post-transfusion." 10. At 1:30 PM on 02/21/12, staff member #A2 indicated he/she did the blood transfusion training and confirmed the medical record findings and indicated the issue time on the TAR should have been changed to the time the unit was taken out of the cooler that came from the other hospital.			

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S1014	410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c) (c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals. Based on document review and staff interview, the facility failed to maintain temperature control for the Pharmacy medication storage refrigerator per policy and procedure. Findings included: 1. The Pharmacy Refrigerator and Freezer Policy states, "Acceptable temperature ranges are as follows: Refrigerator 2-8 degrees C (36 to 46 degrees F); if any refrigerator temperature falls out of acceptable ranges, maintenance must be notified immediately and the pharmacist must isolate these items until stability/usability can be determined." 2. The Refrigerator temperature log of the medication storage refrigerator located in the Pharmacy was reviewed. Five of the last 15 recorded Minimum temperatures revealed the temperature	S1014	· Pharmacy staff re-educated on properly logging medication refrigerator temperatures · Temperature log changed to help easily identify out of range temperatures · Pharmacy staff educated on the procedure to follow if there is an out of range reading and where to document the corrective action taken · New thermometers were purchased for the medication refrigerators (NIST certified High-Accuracy Thermometer) **Responsible Party:** Director of Pharmacy	03/16/2012

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	that was recorded by staff on the temperature log to be lower than the acceptable minimum temperature of 36 degrees Fahrenheit. The log had not corrective action taken noted in the column that was provided on the refrigerator temperature log. 3. At 2:00 PM on 2/22/2012, staff member A10 indicated the temperatures he/she recorded on the temperature log were out of the acceptable temperature range. The staff member indicated he/she did not contacted the pharmacist nor the Maintenance Department about the low recorded temperatures.			

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S1162	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8(d)(2)(A) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (A) All mechanical equipment (pneumatic, electric, or other) shall be on a documented maintenance schedule of appropriate frequency and with the manufacturer's recommended maintenance schedule. Based on documentation review and staff interview, the facility failed to ensure the nurse emergency call (code) systems had preventive maintenance (PM) for the patient rooms and restrooms. Findings included: 1. Policy #636, Equipment Preventive Maintenance, states, "Preventive maintenance will be performed on all equipment to prolong equipment life and to insure efficient operation and reliability of the equipment. This will be accomplished on an ongoing basis. Turn off all switches, as appropriate, and disconnect and/or store line cord. Check line cord for any damages." Policy #631, Call Cords and Bed Controls, states "To	S1162	· The policy “Equipment and Preventative Maintenance” will be revised to add the nursing call system to the list of items requiring PM# of nursing call systems PM'd/ total # of nursing call systems· PM log established for the nursing call system· The PM logs will be reported to the EOC committee · The EOC committee will then submit information to the next Quality Council Committee meeting **Responsible Party:** Director of Plant Ops	03/16/2012

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	minimize time when a defective cord is needed for replacement. All defective call cords and bed control cords will be replaced by the maintenance personnel or Universal Hospital Services. When a non working cord is detected maintenance personnel or UHS will be notified immediately so a working cord can be installed." 2. At 12:15 PM on 2/21/2012, staff member #3 indicated he/she does not conduct any preventive maintenance on the nurse emergency code system. The staff member indicated the facility has pull strings in the restrooms and nurse call buttons in the patient rooms. The staff member confirmed he/she could not provide PM documentation for the nurse emergency code system.			

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S1168	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 150-1.5-8 (d)(3) (d) The equipment requirements are as follows: (3) Defibrillators shall be discharged at least in accordance with manufacturers recommendations and a discharge log with initialed entries shall be maintained. Based on document review and staff interview, the facility failed to ensure every shift conducts operational checks as required by the manufacturer. Findings included: 1. The Zoll M-series Operator's Guide states, "The following operational checks should be performed at the beginning of every shift to ensure proper equipment operation and patient safety..." 2. The two Crash Cart Checklist logs were reviewed for January and the first 20 days of February of 2012. The facility's 2 crash carts store a defibrillator each. Crash Cart #2 evidenced that the defibrillator did not have its require daily shift test for 1 time on the first shift and 3 times on the 2nd shift. 3. At 12:05 PM on 2/21/2012, staff member #3 indicated the facility operates	S1168	· The charge nurses were re-educated on recording the operational checks of the crash cart and completing the checklist dailyAudit of operational checks will be done for compliance· The log will be submitted through the EOC Committee along with any necessary corrective actions taken **Responsible Party:** CCO	03/27/2012

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	under 2 shifts: 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM. The staff member indicated the facility has 2 Zoll M-series defibrillators.			

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S1186	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E)(i)(ii)(iii)(iv)(v) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.			
	Based on observation, documentation review, and staff interview, the facility failed to maintain a safe and healthy environment. Findings included: 1. Policy #708, Fire Safety Management Plan, states, "The fire alarm system is inspected, tested, and maintained by TCSI Technology Contracting Services Incorporated. The established program includes. but is not limited to quarterly	S1186	· All hospital dampers identified by Director of Plant Ops· All dampers tested and documented# of dampers PM'd/ total # of dampers· Dampers placed on scheduled PM· Fire Drill matrix established to track the required drills on each shift· Monitoring of compliance will be submitted to the EOC Committee · The EOC committee will then submit information to the next Quality Council Committee meeting **Responsible Party:** Director of Plant Ops	03/16/2012

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	testing of all circuits and annual preventive maintenance of all components. The hospital has a fire detection system that minimizes smoke transmission by controlling designated fans and dampers in air-handling and smoke management systems. Inspection and maintenance of fire/smoke dampers complies with NFPA 90A. The Director of Plant Operation is responsible for the identification and maintenance of all fire/smoke dampers to ensure proper operation." 2. At 12:00 PM on 2/21/2012, staff member #3 indicated the facility does not have any testing documentation on the fire/smoke dampers within the hospital. The staff member confirmed the smoke dampers should be on a preventive maintenance schedule. The staff member new the hospital has fire/smoke dampers, but was not sure if the hospital has 3 or 4 dampers. 3. Policy #708, Fire Safety Management Plan, states, "Fire drills, totaling at least 1 per shift per quarter per open nurse unit..." 4. The fire drills were reviewed for the year 2011. One of the four quarters evidenced a fire drill was not conducted for the 2nd shift of the third quarter.			

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	5. At 12:05 PM on 2/21/2012, staff member #3 indicated the facility operates under 2 shifts: 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152027	A. BUILDING 00 B. WING	02/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S1197	410 IAC 15-1.5-8 PHYSICAL PLANT 410 IAC 15-1.5 (f)(3)(F) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (F) Maintenance of written evidence of regular inspections and approval by state or local fire control agencies. Based on document review and staff interview, the facility failed to evidence through the Fire Safety Management Plan, routine inspections by the state or local fire control agencies. Findings included: 1. At 12:00 PM on 2/21/2012, staff member #3 was unable to locate when the last fire safety inspection was done by the State Fire Marshall and the staff member did not know when the last inspection was conducted. 2. The Safety Management Plan policy #701 was reviewed and it lacked that the facility should have written evidence of regular fire control inspections by state or local fire control agencies.	S1197	Contact made with local/city/state fire Marshall for Fort Wayne jurisdiction (Craig Bosselman) Craig Bosselman present at Vibra of Fort Wayne on 3/19/12 for Fire Marshall inspection.Responsible Party: Director of Plant OpsADDENDUM: Fire Management Plan updated to show that local Fire Marshall to inspect facility annually.	03/19/2012

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S1510	410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(b)(2)(A)(B)(C) (b) The emergency service shall have the following: (2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following: (A) Provision for the care of the disturbed patient. (B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care. (C) Provision for transfer of patients when care is needed which cannot be provided. Based on medical record review, policy and procedure review, and interview, the facility failed to follow its process for transferring patients in 6 of 6 transfer patient records reviewed (#N9, N10, N11, N12, N13, and N16). Findings included: 1. The medical records for transferred patients #N9, N10, N11, N13, and N16 lacked documentation of a physician's transfer order.	S1510	· Inter-facility transfer process training completed# of patients transfered with appropriate form/ # of patients transfered· Monitoring the compliance with the transfer form and the transfer order will be submitted to the Critical Care Committee Critical Care Committee will then submit the information to the next Quality Council meetingResponsible Party: CCO	03/27/2012

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	2. The medical records for transferred patients #N9, N10, N11, N12, N13, and N16 lacked any interfacility transfer reports. 3. The facility policy titled "Transfer of patient to another facility-Interfacility", last reviewed 4/27/11, indicated, "...A physician's order specifying the new facility is required for transfer of a patient. An interfacility transfer report is to be completed by the nursing staff." 4. At 1:35 PM on 02/22/12, staff member #A2 confirmed the lack of transfer orders and paperwork in the medical records.			